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Some Charting Methods Put Sued EPs in a Tough Spot

Consider your defense

What an emergency physician (EP) documents can unquestionably influence the outcome of a lawsuit, but is the same true for an ED's charting method?

"I have come up against this issue a lot. I think short, standardized forms can be very tough to defend from," says **Michael Blaivas**, MD, RDMS, professor of emergency medicine in the Department of Emergency Medicine at Northside Hospital Forsyth in Cumming, GA.

Blaivas has seen multiple lawsuits in which the triage nurse initially used a standardized form for abdominal pain or nausea/vomiting, and the patient was later found to have a myocardial infarction after a lengthy ED stay or post-discharge.

"It is always painted by the plaintiff's council that the physician was off base from the beginning," he says. "If you have changed direction in the case, the documentation simply does not allow for it."

While EPs using standardized forms are able to claim something was negative simply because it wasn't checked, a dictation leaves little room for doubt as to whether something was done. However, if something *isn't* covered, such as an extremity examination, it's harder for the EP to argue that in fact it was done and normal.

"In all honesty, standardized forms seem to help sub-par physicians and hurt those who are above par," he says. Electronic standardized forms may create problems if a dictated portion isn't available until sometime after the patient's initial ED visit, or before test results are back, adds Blaivas.

"However, I have never seen anyone *not* be able to argue that it takes time for someone to transcribe the report and it was not available yet, and so the EP went by the patient's history," says Blaivas.

The EP can explain that the decision to send a patient home was reasonable at the time of the dictation, for instance, and the corrected and now elevated D-dimer results were not yet available.

Blame Documentation?

Blaivas says that that careful and thorough documentation is hardest for

a plaintiff's attorney to attack, but this can't be achieved for complicated cases using a short, standardized form. Any template that does *not* allow the jury to follow the train of thought of the physician, or the time-line in the ED, raises questions that the plaintiff can exploit, he explains.

On the other hand, Blaivas has seen cases defended involving standardized forms that weren't completely filled out by EPs, which indicated almost nothing about what occurred or the decisions made.

In these cases, the EPs simply blamed the documentation for not having enough space to fill in information or being too inflexible. "Surprisingly, it can work," says Blaivas. "Some of the toughest ones to follow can be electronic templates, especially since they sometimes sneak in descriptions that are clearly inconsistent with what the physician or nurse noted elsewhere."

EPs should think about where templates have shortcomings, advises Blaivas. "It is always tempting to just document enough to get paid, and not waste too much time on the simple case," he says. "However, it could be the one that gets you sued." ■

Source

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Charting Methods: Each Has Legal Pros and Cons

If time wasn't a factor and if charting were an enjoyable activity, emergency physicians (EPs) would presumably always produce thorough, accurate documentation — a key factor in minimizing legal risks.

"No method of charting is much fun, and time is always short," says **Tom Scaletta**, MD, FAAEM, chair of the ED at Edward Hospital in Naperville, IL. "It behooves hospitals to provide a system that produces efficient, accurate, and robust charting." Here are some of the legal advantages and disadvantages for the most common charting methods, according to Scaletta:

Handwritten charting

"This is often indecipherable, and corrections may appear suspicious in the courtroom," says Scaletta. "Other medical providers need to muddle through the scribble to know what happened." Since handwritten charts require scanning, he adds, they could be lost more easily than electronic versions.

Voice-activated dictation

"This is certainly not as fast as transcription, from the EP's perspective," says Scaletta. "It requires a careful read-through, so the kind of gibberish that you would not want to see in a courtroom exhibit is not overlooked."

Editable templates

These may not reflect what actually happened when a non-standard approach is taken. "They do not personalize the story," says Scaletta. "Every case

tends to look the same, so you cannot keep patients with the same complaint sorted out as easily."

However, Scaletta says that templates are a time-efficient means of creating the standard portions of the chart, including procedure documentation.

"ED information systems that incorporate *exclusively* template-driven charting are cumbersome, resulting in less time at the bedside," says Scaletta. "On the flip side, they can offer some useful decision support and improve safety."

Scribes

There are financial costs to providing assistance with transcription, acknowledges Scaletta, "but it may be even more costly to skimp on this because of resultant lost revenue and increased claims." However, scribed charts require careful editing to be sure the verbatim history paints the correct picture.

"For instance, the word 'dizzy,' in my opinion, should not appear in a history," he says. "It really needs to be clarified as a layperson relaying lightheadedness, vertigo, altered sensorium, or something else entirely."

Scribes may neglect to record information shared by a patient, adds Scaletta, or act in a manner beyond their scope by interpreting what they believe the patient or doctor meant to say.

"Some EPs use scribes to document by exception — 'Use my normal [pulmonary embolism], except if there are crackles in the left lung base.' This could lead to inadvertently documenting a portion of the exam as normal, when it was not examined," he says.

Dictation/human transcription

This is the most expensive charting method, says Scaletta, but it achieves the highest quality for the open-ended portions of documentation, including the history of present illness, medical decision-making, and discussions with other physicians or the patient.

"Free-form documentation requires good storytelling," says Scaletta. "EPs generally are experts in gaining someone's confidence and trust in a matter of seconds, and condensing several days of events in a matter of minutes."

The ideal charting strategy is a hybrid of dictation, human transcription, and editable templates, says Scaletta, such as using a high-quality automated emergency department information system, designing editable templates for standard documentation, and dropping voice clips into the open-ended portions of documentation.

"Have a capable transcriptionist convert the voice clips, look over the final product, and relay concerns to the EP before the documentation is etched in stone," he advises. ■

Source

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"What Was EP Thinking" Is Pivotal During Suit

Dictation is best at this

With some electronic medical record (EMR) documentation systems, plaintiff's attorneys may have a difficult time determining what actually happened during the ED visit.

"To the extent they cannot figure out what is going on, it might be good for the EP if it confuses the issue," says **Jonathan D. Lawrence**, MD, JD, FACEP, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA. "Nonetheless, I am not a big fan of the EMRs — or anything except a dictation — because it so poorly explains the medical decision-making."

Lawrence says that he has a strong personal bias for dictation, because it allows for a more individualized description of the patient encounter.

"Even though it may seem like a routine diagnosis, there may be something about the patient you want to document that doesn't fit inside a neat, prefabricated form," he says. "Dictation allows for all the variabilities."

Dictated records allow the EP to explain in great detail all of the diagnoses being considered, such as thoracic and dissecting aneurysms, myocardial infarction, cardiac tamponade, and pneumothorax for a chest pain patient, and the reasons why each of these was ruled out.

"Of course, none of this will protect you if you are wrong," adds Lawrence. "Nonetheless, if you are a halfway reasonable physician, the fact that you missed something can still be defended because you were thinking the right way. You can't do that on anything but a dictated chart."

Lawrence says he is always pleased to see a dictated chart when he reviews medical records for attorneys. "I always breathe a sigh of relief because I know exactly what the doctor is thinking," he says.

"The only downside is that if there are mistakes, then you have documented that really well."

On the other hand, Lawrence says he finds it difficult to determine what the EP was thinking with standardized forms. "I find those to be the weakest charts to try to defend," he says. "Also, it leaves you open to criticism as to why you didn't check or circle something." ■

Source

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Will Jurors Believe it Was Really Just a Typo?

Careless errors carry legal risks

The final statement,"Doctor X is leaving with the patient," dictated by **Corey M. Slovis**, MD, professor and chairman of the Department of Emergency Medicine at Vanderbilt University Medical Center in Nashville, was regarding a critically ill patient who was being accompanied by the hospital's chief of trauma to the operating room. This was later incorrectly transcribed as "Doctor X is sleeping with the patient."

"The lesson is that one needs to be very vigilant when signing your name to any document," says Slovis. "Unfortunately, when one has seen 20 patients on a shift, it is easy to speed read."

If the word "not" is omitted, it will appear a patient had a positive finding, as with "chest pain not associated with exertion" becoming "chest pain associated with exertion." "This is an issue I've seen more than once," says Slovis. "A simple miss like that can allow plaintiff's attorneys to get very interested."

To avoid this, he advises carefully reviewing all dictated records to be sure these say what you intended.

In one case reviewed by **Jonathan D. Lawrence**, MD, JD, FACEP, an ED physician at St. Mary Medical Center in Long Beach, CA, and assistant professor of medicine at Harbor/University of California Los Angeles Medical Center, a typist left out the word "no," and the inaccurate statement "there were signs of infection" made itself into the patient's chart.

"Unless you are willing to spend a little bit of time proofreading the dictation, these errors can come back and bite you," he says. One potential pitfall is that some dictation systems use default macros such as "ENT exam, normal" to speed up the transcription process.

"That's all well and good if you performed the exam," says Lawrence. "The problem comes if you are using the macros to save time and you didn't actually do what is in the default examination, and a question arises as to whether you actually performed a particular exam."

If jurors have emotionally identified with the plaintiff, adds Slovis, they'll tend to disbelieve an EP who claims to have done something in error. "When the chart does not make sense, physicians run the risk of being seen as either indecisive or disorganized," he says. "It allows the plaintiff's attorney to allege many negative things that are then difficult to disprove."

Clarity is Best Defense

Slovis says that when an error is either perceived or occurs, the EP's best defense is to convey his or her assessment and why the EP is doing or not doing therapies or referrals. "The clearer we are in our history, physical, and assessments, the less likely we are to either be sued, pressured into settling, or losing in front of a jury," says Slovis.

While new generations of voice recognition software are making this charting method more accurate, says Slovis, "like all dictation methods, proofreading is required so that embarrassing errors don't get readily dictated."

Voice recognition offers all of the advantages of the dictated record, notes Lawrence, but carries an increased risk of transcription error. "To the extent that you don't proofread it or have the ability to edit what comes out, it could be problematic," he says. ■

Source

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More Contradictions in EMR Charting

Explanation will be necessary

Some electronic medical record (EMR) systems make it difficult for emergency physicians (EPs) to view the nursing notes, says **Jonathan D. Lawrence**, MD, JD, FACEP, an ED physician at St. Mary Medical Center in Long Beach, CA, and assistant professor of medicine at Harbor/University of California Los Angeles Medical Center, which increases the chance of conflicting information getting into the patient's chart.

"As a physician, you want to be able to easily see what the nurses have written," he says. "When the computer chart gets so voluminous that you have page after page of records, going through them becomes so time-consuming that nobody's going to do it."

This just increases the chances that the nurses' record and the EP's record will have conflicting information, says Lawrence, a situation that makes it more difficult to defend the health care providers.

Lawrence says that in his experience, off-the-shelf EMRs bought from third-party vendors are most problematic, while systems developed in-house in cooperation with actual practitioners work out the best.

"I would say a lot of physicians are not comfortable with EMRs. I don't have too many people that I've run into that are happy with them," he says. "But the type of system used for documentation has to be consistent. If the hospital says we are doing EMRs, and the EP says he doesn't like it, he is not going to be working there."

The EMR may not accurately reflect the encounter with the patient, says Lawrence, such as the patient's attitudes, fears, concerns, or other things that make one patient different from another.

"The other problem with the EMRs is they are often exceedingly inefficient," says Lawrence, adding that some preformed templates don't allow the EP or nurse to proceed unless every box is checked off, which allows for a lot of superfluous material to be inserted in the nursing and physician record.

"That leads to a lot more contradiction between the nurses and doctors that needs to be explained afterward, often much to the plaintiff's delight," says Lawrence.

Filling in Blanks

Since charting with EMRs can be so vague, an EP may be forced to "fill in the blanks" at the time of a deposition, should a lawsuit occur. "But that has its own set of problems associated with it," says Lawrence. "The plaintiff attorney can easily say, 'How can you remember that now, when you didn't write it down then?' 'Sudden memory' looks self-serving."

Any additional time the EP spends documenting is taken away from patient care, he adds. "In general, doctors do the right thing, but mistakes do happen," he says. "What no doctor wants is to do the right thing and then get nailed for it, for an extraneous matter like documentation."

While some emergency medicine groups use scribes to fill out standardized forms for them, Lawrence says that this another source of possible error. He says that one possible solution is to use a standardized form or EMR for simple cases, but allow EPs to dictate complex cases. While standardized forms work well for billing, he says, "that's not of primary importance if you've been named in a lawsuit."

"You never want to defend yourself on the basis of 'I made a clerical mistake.' It just sounds like whining," Lawrence says. "If you made a mistake, own up to it. You would rather have a nice, strong defense — 'This is what I did and why I did it.'"

Paint a Picture

Faced with little except a large number of checkboxes, an EP may simply be unable to remember a specific patient. Every history and physical (H&P) should paint a picture that allows a physician to recall almost all patients, especially the more complicated or unique ones, according to **Corey M. Slovis**, MD, professor and chairman of the Department of Emergency Medicine at Vanderbilt University Medical Center in Nashville.

"A pure checkbox system paints no picture at all," says Slovis. "Although it's the fastest way to document, it's the quickest way to forget."

Any charting system that has a full and complete H&P could actually improve the EP's clinical practice, according to Slovis, as it's an opportunity to reflect on whether they are doing the right thing, and whether it's defensible.

"Would a lawyer or patient advocate agree with your plan, based on the available information?" asks Slovis. "As long as it all rings true, you are making the appropriate disposition." ■

Many ED Admissions Are Motivated by Lawsuit Fears

Emergency physicians' (EPs) decisions to admit or discharge patients are motivated, in part, by liability concerns, according to recent research.

In one study, EPs, and patients admitted primarily for acute coronary syndrome, were both surveyed about the content of communication that occurred, estimates of risk at the time of admission, and the perceived primary purpose of admission.[1]

About a third of patients, and almost half of EPs, reported that coronary risk — the primary motivation for admission — was not discussed. In addition, 11% of EPs said that medical-legal concerns were one reason for their disposition decision, and 27% said that they would not have chosen admission for themselves if they were the patient.

In another study, researchers found that congestive heart failure (CHF) patients discharged from 27 New York and New Jersey EDs dropped by 63% between 1996 and 2010.[2]

While 24% of CHF patients were discharged from EDs in 1996, only 9% were discharged in 2010. The trend of EPs admitting more CHF patients is mainly due to increasing concerns about medical malpractice lawsuits, according to the researchers.

Fear of lawsuits is causing ED physicians to practice "defensive medicine," including ordering needless admissions, according to **David C. Seaberg,** MD, current president of the American College of Emergency Physicians (ACEP). Seaberg is an attending emergency physician with Erlanger Health System in Chattanooga, TN, and former residency director and chairman of the department of emergency medicine at the University of Florida.

"Defensive medicine is not just an emergency medicine problem. This is an issue all through medicine," says Seaberg. "But certainly, there are some additional concerns for emergency medicine. There are a lot of additional factors that make the ED have higher liability."

These factors include the high-stress environment in the ED, the fact that ED physicians don't know their patients, and that ED patients are usually having acute medical conditions, says Seaberg.

"The costs of defensive medicine have been estimated from $37 to $200 billion dollars a year. It's certainly prevalent in the ED," he says. One reason may be the fact that clinical policies utilized by EPs don't address factors such as a patient's social support, whether he or she has a primary care physician, or the ability to get prescriptions filled.

"The kind of care the patient will get as an outpatient isn't really factored into the clinical policies that EPs have to take into account," says Seaberg. "This makes it more difficult to not practice defensive medicine."

Reform on Horizon

ACEP is working on comprehensive liability reform for emergency physicians, reports Seaberg, including the possibility of changing the negligence standard for emergency care.

"If we're going to try to decrease the cost of care, we're going to need some sort of liability reform," he says. "This is not shocking news to anyone in medicine. It's a major problem."

Of 1,700 EPs surveyed by ACEP in May 2011, 53% said fear of lawsuits was the main reason they order the number of tests they do. In part, says Seaberg, this is due to unrealistic expectations of ED patients.

"In some regards, the American public wants 100% certainty, and we can't be 100% certain. We can't guarantee all outcomes," says Seaberg. "EPs do not want to miss anything, no matter how rare."

Seaberg notes that although more than 90% of EPs will face a lawsuit at some point in their career, only 10% of lawsuits will ultimately be successful. "But it only takes one," he says. "Certainly, payouts have increased. There is also a psychological burden if you have to go through a lawsuit."

Even if liability reform were enacted today, Seaberg says that the practice of defensive medicine would likely continue by many EPs for years to come. "It will take a generation to change physician behaviors," he explains. "We trained physicians to order tests rather than follow guidelines and examine patients."

There is a better opportunity for federal tort reform right now than in previous years, adds Seaberg. "We are seeing a change in the federal level now, due to the mood of the American pub-

lic," he says. "We can't keep spending what we are on health care and be an economically viable country."

Show Thought Process

The reality is that in a busy ED, it may be easier for an EP to simply order a test than to spend time explaining to a patient why it's not indicated.

Seaberg recently treated a patient who bumped her head but had no loss of consciousness and didn't meet the criteria for ordering a head CT scan. Even though he explained that there was only a 1 in 1,000 chance that the CT would show anything, the patient still insisted on it, and the test was ordered. "We can explain the science behind it, but we don't want to get argumentative. It can affect our customer-service scores," he adds.

If you choose not admit a patient or order a test because you don't think it's clinically indicated, document your thought process, advises Seaberg. "That gives you the best defense in any medical liability case," he says.

This should include what you explained to the patient, the fact that the patient agreed not to have the test or be admitted, the fact that he or she has access to a primary care physician, and the fact that he or she understood the discharge instructions.

"The doctor's note section on your medical record is the most important part of your record," says Seaberg. ■

REFERENCES

1. Newman DH, Shah KH, Ackernam BE, et al. Communication and perceptions of risk among physicians and patients with potential acute coronary syndromes. *Ann Emerg Med* 2011;58(4):S210.
2. Lenehan PJ, Esking B, Allegra JR. The percentage of congestive heart failure patients discharged from the emergency department is decreasing. *Ann Emerg Med* 2011; 58(4):S237.

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"How Could You Have Let This Person Leave Your ED?"

AMA patient doesn't necessarily assume all risk

Suppose a patient is being seen in your ED for an extremity injury resulting from a motorcycle accident, and chooses to leave right after his arm is put in a splint, although the emergency physician (EP) hasn't yet done a full examination.

"If that patient leaves and encounters a serious problem as a result, the patient may later say, 'The doctor didn't completely examine me,'" says **Arthur R. Derse**, MD, JD, FACEP, professor of bioethics and emergency medicine at the Medical College of Wisconsin. "When something bad happens, a patient may suddenly not remember that they were the ones to leave."

Derse says that one risk-reduction strategy is to be sure the patient leaving against medical advice (AMA) hears about the risks he or she is assuming by not completing the medical workup. Document that this discussion took place, and obtain the patient's signature.

"Even if they don't sign it, have someone else sign it as a witness that you gave them this information," he recommends. The form should contain language that acknowledges that the patient is leaving against medical advice and understands the risks of disability or death that may ensue from the patient's refusal.

"It is helpful to list specific risks that the patient may be assuming," adds Derse. "Even patients who are noncompliant are often willing to sign an AMA form to indicate that they no longer wish to stay in the ED and understand the risks of leaving against medical advice."

However, a subset of patients will refuse to sign any AMA form. "If a patient elopes without telling anyone before leaving, the ED physician should document as much as possible of any conversation of risks that had occurred," says Derse.

Patients who leave AMA without giving the EP an opportunity to discuss risks will have a difficult time establishing the EP's responsibility for discussion of risks, he adds. However, patients who might be an imminent danger to themselves or others should not be left unattended.

It is helpful if the ED patient has signed a form stating that he or she was informed of the risks of leaving the ED, says Derse, in the event the patient

later sues, because it memorializes the conversation.

"But ultimately, the jury will decide the question of whether the patient was informed adequately that leaving would impair the EP's ability to make a diagnosis, and the patient could encounter disability or death," says Derse.

While it's possible that a jury would consider that an ED patient leaving AMA has assumed all of the risk of a future bad outcome, this isn't always the case.

In fact, says Derse, one of the most difficult legal scenarios is when a patient, such as a non-compliant substance abuser, refuses treatment and later dies. The jury will want to know "How could you let this person, in this state, leave your ED?"

"That's where it's important to have documentation or witnesses to the encounter," says Derse. "The plaintiff may have been unsympathetic. But now, it's a very sympathetic family member in front of the jury, wondering why their loved one's problems were missed."

There are many reasons why a patient would choose to leave the hospital AMA, but regardless of the reason, the ED physician needs to be aware that it is a patient's right to refuse treatment, according to **Justin S. Greenfelder,** JD, a health care attorney with Buckingham, Doolittle & Burroughs in Canton, OH. "This assumes that the patient is competent to make this decision," he adds.

If the ED physician has a question in his or her mind whether a patient is competent to decide whether to refuse treatment, the physician should document the incident well, says Greenfelder, and, if possible, obtain a consult from a psychiatrist or other mental health professional, as well as discuss the situation with the attending physician on duty.

If the patient is competent and refuses treatment, the patient should be asked to sign a form indicating he is leaving AMA and assuming the risks of such a decision, says Greenfelder. "While this would be a perfect situation, it is not always possible to obtain a signed consent or clear the patient before he leaves," he says. "Under any circumstances, the situation must be well documented."

Even a signed consent form will not insulate the ED physician from potential liability if the patient later suffers a bad outcome, says Greenfelder, and the lack of effective documentation, even in the absence of a signed consent, will weaken the defense position in a subsequent lawsuit.

"It is difficult to say how far a jury would expect the physician to go in keeping a patient there who wants to leave," says Greenfelder. "Much of this has to do with the patient and whether he or she is able to adequately explain why he or she wanted to leave without obtaining treatment."

If the ED physician has documented the situation well, and is able to explain what happened and why, a jury may be less likely to hold the physician accountable if the patient created the problems for himself, says Greenfelder. "It is likely that if the jury hears the physician say, 'I tried to help him but he just wouldn't let me,' it will shift the burden to the patient to explain his decision to leave AMA," he says.

A juror will typically put him- or herself in the patient's position, and if the juror would not have done the same thing, it is likely that the patient will not engender much sympathy, explains Greenfelder.

If a physician wants to admit a patient involuntarily, this should be a well-considered decision with independent corroboration from the attending or a consulting physician, says Greenfelder. "The quantity of testimony and documentation supporting that decision will make such a decision easier to defend in a subsequent legal proceeding," he adds. ■

Sources

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What Are EP's Legal Responsibilities With AMA?

Although the EP is responsible for medical care delivered in the ED setting, every adult of sound mind has the right to refuse medical care, says **Catherine A. Marco,** MD, FACEP, a professor in the Department of Emergency Medicine at The University of Toledo (OH).

When a patient refuses care, the EP has a duty to inform him or her of the risks involved, and alternatives to the proposed medical intervention, she explains.

For example, a patient may present to the ED with ankle pain, and requests pain control and a brace, but refuses X-rays. In such a case, it is the duty of the emergency physician to inform the patient of the risks of foregoing the diagnostic test and potential consequences, says Marco — in this case, a potential missed fracture, delays in healing, nonunion, and chronic pain.

"The physician also has a duty to provide the best possible medical care that the patient will consent to," she says. "Beyond that, patients with decisional capacity should not be forced to undergo interventions that they refuse."

In such circumstances, the patient is accepting responsibility for his or her voluntary refusal of care, says Marco. "Unfortunately, there are still potential legal risks in any scenario," she says. "But with appropriate actions and appropriate documentation, the risk can be minimized and the physician's actions can be defended."

For example, if a patient leaves AMA, and later sues the treating physician for a bad outcome, it would be helpful to the defense to refer to the documentation that all of the appropriate information was given to the patient, and that the patient made a voluntary decision to refuse medical care.

Without the appropriate documentation, the plaintiff's argument might be that the plaintiff was not fully informed, and that he or she would have agreed to therapy, had he or she known of the potential risks.

Marco advises documenting the assessment of decisional capacity, delivery of information, including risks, benefits, and alternatives, the patient's deliberation, the patient's voluntary decision, and reasons for the decision.

"It is also helpful to document patient education and any attempts to work with the patient to resolve their concerns," she says.

Even if the patient refuses to sign the consent form, says Marco, the EP's documentation of the essential elements of the informed refusal process is important.

It is reasonable for the EP to detain a patient until decisional capacity can be evaluated, adds Marco. "It is prudent to follow the steps of delivery of information, including risks, benefits, and alternatives, and attempt to deliver the best possible medical care," she says.

If the situation doesn't appear serious enough to warrant involuntary admission, the EP should document findings at the time of the ED encounter, says Marco, including evaluation of mental status and decisional capacity.

"It is crucial for the physician to meet the standard of care for each individual case," she says. "That being said, there is never a guarantee of what will occur following the ED visit."

It is difficult to predict what juries will be sympathetic to, says Marco. "It is crucial for physicians to provide the best possible medical care for each individual patient. That is always the best defense." ■

Source

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Study: Temporary ED Staff Twice As Likely To Be Associated With Medication Errors That Cause Harm To Patients

Consider orientation programs, seasoned guidance to ensure temp personnel are prepared to deliver quality care

This article originally appeared in the December 2011 issue of ED Management.

Busy EDs are increasingly relying on temporary staff to cope with nursing shortages, unanticipated spikes in volume, and other personnel challenges, but the practice is coming at a steep price, according to research from Johns Hopkins University (JHU) School of Medicine in Baltimore, MD. A new study, led by **Julius Cuong Pham**, MD, PhD, an assistant professor of anesthesiology, critical care, and emergency medicine at JHU, suggests that temporary staff working in the ED are twice as likely as permanent staff to be associated with the kind of medication errors that actually harm patients.[1]

While researchers did not look at the specific reasons for this association, there are some obvious possibilities. Temporary staff may be unfamiliar with regular policies and procedures, for example, but there could also be deeper problems involved, says Pham. "A hospital may be experiencing a lot of turnover of regular staff, it could be rapidly expanding, or perhaps it is taking in more patients than it can adequately take care of with its normal staff," he says. "This may be a sign that the organization's local resources are overwhelmed."

Whatever the underlying causes, the study's findings suggest that ED managers should consider safeguards to ensure that the temporary nursing staff are adequately prepared and positioned to deliver high-quality care.

Take Advantage of Former Full-timers

Pham decided to take a closer look at the issue because he saw that not only is the use of temporary staff increasing in the nation's hospitals, but experts are predicting that the current nursing shortage will become more acute in the next few years with anticipated retirements. Also, through JHU's affiliation Medmarx, a national Internet-based medication error reporting system, Pham and his research colleagues had access to a treasure trove of data that could shed light on this issue. Pham felt that any association between the use of temporary staff and medication errors would be felt most acutely in the ED because of the unique pressures that occur in the emergency environment.

By completing a cross-sectional study of Medmarx data from between the years 2000 and 2005, the researchers found that a total of 23,863 medication errors were reported in the EDs from 592 hospitals. Further, the researchers reported that the errors committed by temporary staff were more likely than the permanent staff errors to require patient monitoring, result in temporary harm, or to be life-threatening.

Researchers emphasize that it would be a mistake to place the blame for these errors on the temporary staff themselves. Instead, Pham suggests that hospitals should carefully assess the way they are using and training temporary staff to see if any revisions are in order. "Depending on how often you use temporary staff, it may be more [financially] beneficial to hire permanent staff to fulfill these roles," he explains. While temporary staff typically earn more per hour than permanent staff, hospitals usually don't pay for their benefits.

However, Pham recognizes that many organizations utilize temporary staff not because of any financial advantage, but to cover personnel shortages. "In these cases, hospitals are in a difficult position because if they don't hire temporary staff, then the positions go unfilled and they are short-staffed," he says.

One strategy that JHU uses with success is to rely on temporary nurses who used to be full-time employees within the system. "Some people just like to be temporary staff because of the flexibility in their hours and the fact that they don't have to be involved with some administrative tasks," he says. "If they can get their benefits elsewhere, the option can be appealing."

In addition, JHU provides an extensive training period for temporary staff who have never worked at JHU or are unfamiliar with a particular division or department, says Pham. "We give them quite a bit of time so that they are oriented to our local systems, our local culture, and how we do things before they can practice on their own," he says.

Link Temporary Staff With Seasoned Veterans

Unanticipated surges in patient volume can occur, but oftentimes such surges are predictable, explains **AnnMarie Papa**, DNP, RN, CEN, NE-BC, FAEN, the 2011 president of the Des Plaines, IL-based Emergency Nurses Association and clinical director of emergency nursing at the Hospital of the University of Pennsylvania and Penn Presbyterian Medical Center in Philadelphia, PA. "If you are located in a winter resort area, there is just no way around having temporary help because your census can go from 40 patients one day to 140 patients the next day because the season has opened," she says. "The best thing that hospitals can do is plan to on-board their temporary staff and ensure that these nurses have adequate orientation."

In addition, Papa stresses that ED leaders need to make sure that a process is in place to ensure that every temporary staff person has a seasoned nurse he or she can go to with any questions or concerns. Ideally, the mandate for this kind of practice should come from ED leadership, but charge nurses should be responsible for actually connecting a temporary nurse with a resource nurse and for making sure that this connection is effective. "The charge nurse should make rounds and ask how things are going," says Papa. "If

the individual who was assigned to be a temporary nurse's resource person is not stepping up to the plate, then the charge nurse has to have the authority to step in."

This type of model provides temporary staff with an additional resource person because they can also go to the charge nurse if they need assistance or information. This kind of support is essential, stresses Papa. "What happens sometimes is the culture is not welcoming to new on-boarded or temporary nurses," she says, explaining that this can make temporary staff reluctant to ask questions or voice concerns. "Sometimes there is just a sense of resentment … or a tendency for what we call lateral violence. And if that culture is allowed to permeate through the department, then the bottom line is that the person who is the biggest loser from all of this is the patient."

By the same token, however, ED leaders need to recognize that it can be distracting and burdensome to be constantly bringing temp personnel up to speed. To get around this problem, Papa notes that administrators need to find ways to show their appreciation for valued nurses who are capable and willing to provide this kind of seasoned guidance. "This can be as simple as throwing a party, providing gift cards, or establishing a preceptor award," says Papa. "There just needs to be some type of recognition."

Effective communications and a welcoming culture will go a long way toward eliminating errors, but Papa says it also helps to have a pharmacist as a resource in the ED, or at least a pharmacy hotline that nurses can call when they need a quick answer. "In the ED, you can't wait an hour for an answer, and sometimes 10 minutes is too long to wait, so this has to be a priority for the hospital," she says. ■

REFERENCE

1. Pham J, Andrawis M, Shore A, et al. Are temporary staff associated with more severe emergency department medication errors? *Journal for Healthcare Quality* 2011; 33:9-18.

Sources

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- Medmarx (www.medmarx.com) is a national registry of adverse drug events that is compiled through a subscription-based, voluntary reporting system offered by Quantros, Inc., in Milpitas, CA. Phone: 877-782-6876. Web: www.quantros.com.

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CNE/CME QUESTIONS

1. Which is recommended regarding documentation if an emergency physician (EP) chooses not to admit a patient because he or she doesn't believe it's clinically indicated, according to **David C. Seaberg**, MD?
   A. The EP should document what was explained to the patient.
   B. The EP should not refer to the fact that the patient agreed not to be admitted.
   C. It is not advisable to document the fact that a patient has access to a primary care physician.
   D. The EP should avoid specifying whether that the patient understood his or her discharge instructions.

2. Which is recommended regarding a patient leaving against medical advice, according to **Justin S. Greenfelder**, JD?
   A. The EP should avoid documenting specific risks the patient is assuming.
   B. If the patient refuses to sign a consent form, it is not advisable to have someone else sign it as a witness that you gave the patient the information.
   C. If the patient elopes without telling anyone, document conversations about risks that occurred before the patient left the ED.
   D. A signed consent form will insulate the ED physician from potential liability if the patient later suffers a bad outcome.

3. Which is true regarding if the ED physician has a question in his or her mind as to whether a patient is competent to decide whether to refuse treatment, according to Greenfelder?
   A. A juror will typically put him- or herself in the patient's position, and if the juror would not have done the same thing, it is likely that the patient will not engender much sympathy.
   B. The EP should avoid obtaining a consult from a psychiatrist or other mental health professional.
   C. It is not advisable for the EP to discuss the situation with the attending physician on duty.
   D. If a physician wants to admit a patient involuntarily, he or she should not obtain independent corroboration from the attending or a consulting physician.

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After completing this activity, participants will be able to:

1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice. ■

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- identify legal issues related to emergency medicine practice;
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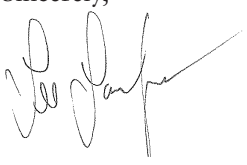

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